WYOMING WORKERS' SAFETY AND COMPENSATION DIVISION
P.O. Box 20207, Cheyenne, WY 82003-7005
1-307-777-7441 Fax: 1-307-777-6552

EMPLOYEE'S APPLICATION FOR TEMPORARY TOTAL DISABILITY BENEFITS

NAME (PRINT):		CASE NUMBER:
ADDRESS:		DATE OF BIRTH:
CITY, STATE, ZIP		SOCIAL SECURITY NUMBER:
IS THIS A NEW ADDRESS? YES ☐ NO ☐	DATE OF INJURY:	PHONE NUMBER:

1. ARE YOU WORKING OR HAVE YOU WORKED PART-TIME OR FULL TIME SINCE THE DATE OF YOUR INJURY IN A JOB OR SELF-EMPLOYMENT THAT IS ORDINARILY DONE FOR PAY? YES ☐ NO ☐
2. HAVE YOU ASKED YOUR EMPLOYER FOR SUITABLE DUTIES THAT ACCOMMODATE YOUR PHYSICAL CONDITION? YES ☐ NO ☐
3. ARE YOU RECEIVING UNEMPLOYMENT INSURANCE COMPENSATION? YES ☐ NO ☐
4. ARE YOU REQUIRED TO MAKE CHILD SUPPORT PAYMENTS BY COURT ORDER? YES ☐ NO ☐

By signing below, I hereby make application and claim for temporary total disability benefits. I understand the Division will rely on current medical opinion and current medical literature to determine my eligibility for these benefits.

Under penalty of prosecution for false statement, I swear that the information given by me herein is true and correct. I authorize the Division to obtain from any source and release to other agencies, insurers or employers, any medical, employment or payroll information needed to determine eligibility under the Workers' Compensation Act. A copy of this release has the effect of the original.

I agree to notify the Division (my case analyst) and my health care provider(s) immediately if I return to any work after applying for this benefit.

EMPLOYEE SIGNATURE	DATE:

HEALTH CARE PROVIDER'S CERTIFICATION OF TEMPORARY TOTAL DISABILITY

THIS CERTIFICATION FULFILLS THE REQUIREMENT UNDER WS 27-14-404 AND 27-14-501(B) FOR TTD BENEFITS. THE HEALTH CARE PROVIDER SHALL EXAMINE THE INJURED EMPLOYEE AND FILE THIS WRITTEN REPORT WITH THE WYOMING WORKERS' SAFETY AND COMPENSATION DIVISION.

FEDERAL TAX ID #:	DATE OF LAST EXAM BY THE CERTIFYING HEALTH CARE PROVIDER:
HEALTH CARE PROVIDER'S NAME (PRINT OR TYPE):	DATE OF NEXT APPOINTMENT:
ADDRESS:	IS SURGERY INDICATED? YES ☐ NO ☐
CITY, STATE, ZIP:	NUMBER OF ANTICIPATED FOLLOWUP VISITS:
PHONE #:	REFERRED TO:
DIAGNOSIS:	HAS THE PATIENT'S INJURY RESULTED IN AN ASCERTAINABLE LOSS?
WORK RELATED? YES ☐ NO ☐ UNABLE TO DETERMINE ☐	(WYOMING STATUTE 27-14-102(A)(II): THAT POINT IN TIME WHICH IT IS APPARENT THAT PERMANENT PHYSICAL IMPAIRMENT HAS RESULTED FROM THE INJURY, THE EXTENT OF THE IMPAIRMENT CAN BE DETERMINED AND THE IMPAIRMENT WILL NOT SUBSTANTIALLY IMPROVE OR DETERIORATE BECAUSE OF THE INJURY
DATE EMPLOYEE WILL BE ABLE TO RETURN TO FULL DUTY WORK:	YES ☐ NO ☐
IS THE PATIENT ABLE TO RETURN TO MODIFIED DUTY AT THIS TIME? YES ☐ NO ☐	IF YES, CAN YOU PROVIDE A RATING ACCORDING TO THE MOST CURRENT AMA GUIDES TO THE EVALUATION OF PERMANENT IMPAIRMENT?
IF YES PLEASE NOTE RESTRICTIONS:	YES ☐ NO ☐

BASED ON MY EXAMINATIONS, CONDUCT AND STATEMENTS OF THE EMPLOYEE, I HEREBY CERTIFY THAT I HAVE EXAMINED THE ABOVE PATIENT WITHIN THE LAST SIXTY (60) DAYS AND THAT THE ABOVE PATIENT IS TEMPORARILY DISABLED FROM RETURNING TO ANY GAINFUL EMPLOYMENT EXCEPT AS SET FORTH ABOVE. THE EXPECTED DURATION OF TEMPORARY TOTAL DISABILITY IS:

FROM:	THROUGH:
SIGNATURE, HEALTH CARE PROVIDER:	
DATE:	

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